Illinois Department on Aging

ADAD-PN3

Illinois Cares Rx Program
Authorization for Use or Disclosure of Medical Information

Read this information first

You should complete this form if you wish to authorize us to use or disclose your medical information to persons who are not directly involved in making decisions regarding your health care. This authorization remains in effect until the date you specify or the date you revoke it.

Note We allow you to call us and give a verbal agreement over the telephone to disclose your medical information to persons who are directly involved in making decisions regarding your health care. To do so, please call **1 800 624-2459** (8 a.m. to 5 p.m. weekdays) or **1-800-544-5304** (TTY).

Mail this form to: Illinois Cares Rx, Illinois Department on Aging, P.O. Box 19021, Springfield, IL 62794-9021.

Step 1: Complete the participant's or applicant's information

1 _____
Participant's or applicant's name

2 ☐☐☐ ☐☐ ☐☐☐☐
Participant's or applicant's SSN

Step 2: Tell us what medical information may be used or disclosed

3 Check the appropriate box to indicate what information may be used or disclosed.

a My entire record. ☐

b Other (specifiy)_____ ☐

4 Check the appropriate box to indicate the purpose of the use or disclosure.

a At my request. ☐

b Other (specifiy)_____ ☐

Step 3: Tell us who you are authorizing to use or receive your medical information

5
_____ Name of authorized person
_____ Address of authorized person
_____ City State ZIP
_____ Phone

6
_____ Name of authorized person
_____ Address of authorized person
_____ City State ZIP
_____ Phone

7
_____ Name of authorized person
_____ Address of authorized person
_____ City State ZIP
_____ Phone

8
_____ Name of authorized person
_____ Address of authorized person
_____ City State ZIP
_____ Phone

Note **Optional:** authorization termination date: __ __ / __ __ / __ __ __ __
Month Day Year

Step 4: Complete your acknowledgment

I understand and acknowledge that:

- I have received a copy of Form ADAD-PN, Illinois Cares Rx Program Privacy Notice;
- I do not have to complete this authorization and my refusal will not affect my prescription coverage unless the authorization is necessary to determine my eligibility for benefits;
- The information used or disclosed by this authorization may be at risk for redisclosure by the recipient and no longer protected by federal privacy laws;
- I have a right to revoke this authorization at any time by completing and sending to the department, Form ADAD-PN4, Revocation of Authorization (except to the extent that action has already been taken in reliance on this authorization); and
- If the department seeks an authorization from me for use or disclosure of my medical information, the department will provide me with a copy of the signed authorization.

9 _____
Participant's, applicant's, or personal representative's signature

__ __ / __ __ / __ __ __ __
Month Day Year

10 _____
Personal representative's relationship to participant or applicant